MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
April 18, 2013, 9:30 am to 3:00 pm
ChildServe, Training Center
5406 Merle Hay Road, Johnston, Iowa
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick
Lynn Crannell
Richard Crouch
Jill Davisson
Richard Heitmann
David Hudson
Lynn Grobe
Gary Lippe
Zvia McCormick
Laurel Phipps
Deb Schildroth
Patrick Schmitz
Susan Koch-Seehase
Dale Todd
Suzanne Watson
Gano Whetstone
Jack Willey

MHDS COMMISSION MEMBERS ABSENT:

Senator Joni Ernst
Senator Jack Hatch
Representative Dave Heaton
Representative Lisa Heddens
Chris Hoffman

OTHER ATTENDEES:

Theresa Armstrong	MHDS, Bureau Chief, Community Serv. & Planning
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI
Craig Bradke	Abbe Center
Diane Brecht	Penn Center Inc.
Lynsie Crawford	Deaf Services
Connie Fanselow	MHDS, Community Services & Planning
Denise Fink	Vera French
Jim Friberg	Department of Inspections and Appeals
Gayla Harken	Story County Community Life/IACP
Melissa Havig	Magellan Health Services
Betty King	Mental Health Advocate
Meghan Klier	Easter Seals of Iowa
Todd Lange (by phone)	Office of Consumer Affairs
Geoff Lauer (by phone)	Brain Injury Alliance of Iowa
Sylvia Mork	Prairie View Management
Larry Murphy	Alliance for Residential Treatment
Liz O'Hara	U of Iowa Center for Disabilities and Development
Mike Porter	Pride Group/Residential Care Facilities
Renee Schulte	DHS Consultant
Marilyn Seemann	Woodward State Resource Center

OTHER ATTENDEES (continued):

Rick Shults	DHS, Administrator MHDS Division
Deb Eckerman Slack	ISAC, County Case Management Services
Dave Smith	DAC, Inc.
Robyn Wilson	MHDS, Community Services & Planning
Ann Wood (by phone)	Office of Consumer Affairs

WELCOME AND CALL TO ORDER

Jack Willey called the Commission business meeting to order at 9:35 a.m. and led introductions. Quorum was established. No conflicts of interest were identified for this meeting.

APPROVAL OF MINUTES

Richard Heitmann made motion to approve the minutes of the March 21, 2013 meeting as presented. Patrick Schmitz seconded the motion. The motion passed unanimously.

UPATE ON COUNTIES FORMING INTO REGIONS

Rick Shults shared an updated map showing how counties are currently grouping in preparation for forming regions. He noted that the regional groups are not yet final and more changes are anticipated before the regions are finalized. DHS has received 98 letters of intent from counties; 94 of those are for joining into regions and 4 (Carroll, Polk, Jefferson, and Van Buren) are for counties to be exempted from regions and stand alone. Van Buren County has also continued to have discussions with other counties and may decide to join a regional group. Polk County submitted its application to be approved as a stand-alone county along with its letter of intent and Director Palmer has approved it. The remaining county (Ida) is still talking to other counties in the area. Madison County has decided to join with a noncontiguous group of counties; Boone and Madison counties have shared a CPC for a number of years, so they have an established relationship even though there is a geographic separation.

ADOPTION OF ADMINISTRATIVE RULES

Rick Shults and Theresa Armstrong introduced the DHS administrative rules for counties to be exempted from joining into regions. These rules were adopted by the Commission through the emergency rulemaking process in January and are now coming back through the regular rulemaking process, following public comment, for approval. Theresa noted that the public comments received, and the Department's responses, have been incorporated; they begin at the bottom of page one and continue to the middle of page five. Rick noted that these are the rules the Director used in approving Polk County's application for exemption. In response to a question, Rick also explained that many of the comments suggested that DHS change the criteria that counties are required to meet to stand alone, but the requirements in the rules were

based on the requirements the legislature put into Iowa Code and could not be changed. He said these rules operationalize the expectations that the legislature laid out for counties and regions. Motion: Gary Lippe made a motion that the Commission adopts the administrative rules for establishing criteria for county exemption from joining into regions and for forming regions of less than three counties to administer mental health and disability services, pending approval of the Administrative Rules Review Committee. Neil Broderick seconded the motion. Discussion: – Jill Davisson asked if there is an appeal process if a county is denied. Theresa Armstrong responded that since no specific appeal process was included in the legislation, it was determined that counties could use the state appeal process. Vote: – The motion passed unanimously.

CORE SERVICES DISCUSSION

Patrick Schmitz reported for the Core Services Committee. The group met on April 9 by conference call and last night (April 17) in Johnston. They have scheduled two more meetings for May 6 and May 15. The first two meetings were spent reviewing a document created by Renee Schulte to pull together core services definitions from the Iowa Code, administrative rules and other policy sources. The first version was about 28 pages long and after adding some items at the committee's recommendation, Renee had about 38 pages for the group to review last night. In a three-hour work session, they went through about three-quarters of the document to begin eliminating unnecessary information and consolidating relevant information into proposed definitions.

Patrick said he knows that people are interested in seeing the document, but it is still a work document of the committee and it would be premature to release it because there is still of lot of information that may or may not be relevant to be sorted through. Theresa added that there will be a document released once the committee has finished its preliminary work and has some recommendations for the full Commission and others to review. Once everyone has an opportunity to comment and provide input on proposed core services definitions, they will be used as a basis for drafting administrative rules. Rick noted that these administrative rules will not go through an emergency process and the regular process takes about 6 months, so the Department and the Commission will be moving as quickly as possible to get the definitions out and make sure that regions have something to rely on as they begin to function. Rick said the concern is that some regions are forming more quickly than is required, so even having a draft of what is anticipated to be in rules will be helpful to them as they plan and begin to operate. Patrick commented that committee members have made a significant commitment of time to get this work done in a fairly short amount of time.

Renee Schulte said her work has focused on finding and pulling together all the definitions that currently exist in Iowa code, administrative rules, the Iowa Plan, SAMHSA (Substance Abuse and Mental Health Services Administration) best practices, and any other sources that have been identified. The definitions are for the items listed in Senate File 2315 for core services. She said that anyone who has something they want to make sure gets seen can share the information with her. The intent is not to

exclude anything, but to take the large volume of information available and formulate a good umbrella definition that clearly identifies the expected floor for core services.

- Current work is on defining the new core services specifically listed in Iowa Code
- Anything that is in Iowa Code does not need to be repeated in rules
- Early drafts and proposed rules will provide guidance to the regions
- Core-plus services will also be defined in a later document
- There will still be plenty of time to add anything that is left out after the document becomes public
- If new legislation is passed that adds more core or core-plus services, those will also need to be defined
- These definitions need to be broad to cover all populations for the system as a whole
- This process may also identify areas where existing rules or definitions are in conflict

Rick noted that the core-plus services area will be more open to new services so there may be more challenging areas to define. There may be areas that cross core and core-plus, such as crisis services, where a clear line will need to be drawn between what is core and what is core-plus. The core-plus rollout will be based on funding availability and there will be some flexibility for counties in deciding how they prioritize those services. The legislation does not specify a priority order for starting core-plus services. Regions will be working to meet outcomes and they may select core-plus services that best support their efforts to do that. If funds are made available for core-plus services regions will be expected to use those funds to provide core-plus services; regions may decide to make some core-plus services available in the absence of core-plus funding. Rick said the regions will be starting with core services that are equitably available across the state and work will be done on adding core-plus services and eventually getting to a point where they are also available statewide. He said this will be a multi-year process of raising the bar for everyone.

David Hudson asked if there are any concerns that regions will have difficulty meeting the floor for core services. Renee responded that services may not look the same all over the state, but that regions are expected to provide what people need to be healthy or recover and the services should be individualized. It was noted it will continue to be important to make sure that funding is at an appropriate level. Deb Schildroth commented that workforce issues will need to be addresses to support the provision of the core services. Dale Todd commented that there have already been service cuts in some areas and meeting the needs of individuals and families should be emphasized.

Rick noted that as a group of informed people, it is important to be vigilant in helping people understand that redesign was not set up to cut back on services. He said that there are a fairly small number of instances where services were cut back because they were not included specifically in the list of core services. In some cases redesign has been pointed to as a reason, but the legislation says that while some specific services are required, many others that are not specifically listed are allowed. For example

support for employment is required, but nothing in the legislation says that sheltered workshops must shut down. He said that people are absolutely going to have the opportunity for integrated employment and the principles of Olmstead are going to be followed, but that does not mean the rug is going to be pulled out from under anyone in terms of services they have been receiving. He said we have to acknowledge that there are limitations because of funding, but there are also a few who want to change services and are citing redesign as the reason, even though it does not require them to do so.

David Hudson asked if core services should be more narrowly defined because there is limited funding. Patrick Schmitz said he thinks broad definitions are important to allow flexibility; being too narrow could create winners and losers and may not leave room for the use of alternatives that may work best for some people. Gary Lippe added that a broader array allows for providing more effective services at a lower cost and said he thinks broader definitions can be more cost effective and effective for people. If services are defined too narrowly it could defeat the purpose of individualizing services and doing what works best for the client and want works best for each of the regions. Jack Willey said that he believes it is important for the governance boards of the regions to have flexibility to determine what they are going to do and what will work best for the people they serve.

Teresa Bomhoff asked if there is a definition for transportation, as it seems to be a problem in so many areas of the state. Renee Schulte responded that transportation is not listed in the legislation as a core service. Items like transportation, sheltered work, and others that are not on the core services lists may go beyond the scope of what can be addressed in these definitions. She noted that transportation is attached to certain services, but is not in the core services adopted last year and is not currently in any of the bills that are moving forward in the statehouse. Jill Davisson said she is concerned that transportation will be a barrier to accessing services. Renee indicated that transportation will come up again when DHS starts working on defining access standards. Rick added that this is a process that will take time and all the problems we encounter across the state will not be solved immediately. Some may require more discussion, more legislation, more rules, or more funding, but focus should be on making progress in the journey.

Renee said that by the end of December the Department will have the first full year set of data for the legislature and that will help identify new issues that still need attention for them to address and prioritize. The Department will do what can be done through rules and if the need for changes in the law is identified, those issues can be taken to the legislature. Rick Shults said this he sees funding as a glass half-full/glass half-empty kind of discussion. The legislature has put a tremendous amount of money into the MHDS services systems to prevent the necessity of drastically cutting services to cover the increased cost of the Medicaid program. There is still a need for more money for both Medicaid and non-Medicaid services and the legislature seem to have heard that message. Rick said he encourages people to continue their advocacy, but also to acknowledge the significant steps forward that have been made in funding the system.

Gary Lippe commented that he sees going from 99 counties to regions as a big step in progress; now that data is being collected, that information can be used to drive more progress. If we find that expectations are not being met, we will need to look at why and work to do better. Patrick Schmitz added that moving from a system by default to a system by design is an important step; we all have a role to continue to advocate when we see something that needs improvement.

Renee Schulte noted that Integrated Health Homes (IHH), which will start within the Medicaid program, include care coordination. Care coordination includes getting people to appointments and they services they need, so that may start a shift with regard to transportation services. Jill Davisson asked if people will lose Targeted Case Management (TCM) to go to IHHs. Theresa Armstrong responded that TCM is not going away. At this time, IHHs are for adults with Serious Mental Illness and children with Serious Emotional Disorders; for those people the care coordination will be through the health home rather than through at TCM.

Gano Whetstone commented that the system seems to put the responsibility on families to do support work for a family member who needs it; the system should do more to make that less of a burden by providing transportation, care coordination, and other supportive services. Laurel Phipps commented that transportation is an important issue for veterans.

PUBLIC COMMENT AND DISCUSSION

Teresa Bomhoff commented that she believes a purpose of Integrated Health Homes is for people to be able to make choices and she hopes that there will be flexibility for them to choose the case management they want.

Neil Broderick commented that Orchard Place will have 2500 children with SED who will need care coordination services under the IHH model on July 1. He said that based on that number, 35 case managers will need to be hired.

Jill Davisson commented that she is very concerned that talented and experienced case managers will be losing their jobs and moving to other types of work, and that people will feel their choice of case manager has been taken away. Theresa Armstrong said that the tasks and responsibilities for care coordinators will be the same as for Targeted Case Managers. She indicated that there will be a more comprehensive discussion of IHHs this afternoon. Melissa Havig from Magellan Health Services said it is not the intention for people to have any gap in services as they move into the IHH and that Magellan wants to work with people is those issues arise.

Suzanne Watson commented that there are a lot of unknowns right now and that case managers are very concerned about losing their jobs. Theresa Armstrong responded that from the business perspective there will be efficiencies, the expectation, however, is that the care coordinators caseload for the people being served by TCM now will not be higher than is it currently; for individuals who have different levels of need, the

caseloads will vary. Neil Broderick said that one of the things Orchard Place is doing to assess risk is to look at the pop being served and come up with a balance, knowing that some people have high needs and others have low needs. He said their analysis showed that about 25% will have a high need. He also noted that parents have the choice of opting out of use of the IHH model. Susan Seehase said there is a real potential for people to have a better quality of life if the professionals were required to plan and talk and work together in a coordinated way.

Mike Porter commented, saying that he was part of a group representing Residential Care Facilities (RCFs), and they are open to change and to providing services in smaller, less restrictive settings. He said RCFs trace their roots back to the time when there were county care facilities to provide care to people who had nowhere else to go, but now also include RCFs/PMI that serve people coming out of acute care settings. He said they believe they help in the recovery process by getting people from acute care to a less restrictive setting and providing a safety net. RCFs want an opportunity to discuss their relationship to the core service process and the role they could play in crisis stabilization and jail diversion. He said he is concerned about the core services definitions and concerned that many RCFs are closing because they cannot make the change. He said RCFs can adapt to system changes such as new buildings and smaller settings, but that will take money. He said he would like the Commission to think about how RCFs can be part of the change.

Craig Bradke from the Abbe Center commented that choice is a principle of the Olmstead U.S. Supreme Court Decision and Olmstead is not just a matter of living in the community. He said there are individuals who are being moved by counties against their choice because the counties want to save money and the individuals being moved don't understand why they do not have a choice. It was noted that Senate File 440 proposes to add RCFs to core services. David Hudson asked where in the definitions Craig would propose the RCFs should be are included. Craig responded that RCFs are a treatment service. Patrick Schmitz said he believes there is a need to define what core services are and provide some guidance on what settings those services can be delivered in; the name "RCF" may not fit with the service that is being delivered. He said he believes people recognize that any abrupt cutoff of services is not good for the folks being served.

Deb Schildroth noted that Senate File 2315 has language that says "including but not limited to" which applies to treatment services, recovery services, and residential services; a service does not have to be specifically listed to be included. Mike Porter commented that he has heard counties say that if RCFs are not listed in core services, they will not fund the service. He said people are being hurt because of that and RCFs are struggling to stay alive. Dave Smith commented that the name "integrated health home" confuses many consumers because they think it is a "home" – a place – that they are supposed to go to. Theresa Armstrong said she recognizes the term does cause some confusion; it comes from the federal level and is used in the Affordable Care Act. She said the "home" is the person's team and we need to work to clarify that with people.

Dave Smith said he is also very concerned about the change to residency coming on July 1; he has heard some counties/regions talking about sending people back to their "home" counties. Theresa responded that counties are working on issues connected with the change to residency and there are challenges in following the legislation; providers should probably we having conversations with counties so that they get an understanding of where the responsibility lies for funding services to their clients. It should be a collaborative process. Patrick Schmitz asked who providers can bring their concerns to when they believe that counties/regions are doing things that are not in accord with the intent and requirements of redesign. Theresa Armstrong responded that they should contact their CPC; if any individual service matter is involved, the individual can access the appeal process.

Suzanne Watson commented that the designation RCF is a license and the discussion has been about a service; it may be time to look at the service as a transitional living environment. Mike Porter added that the RCF licensure is old and providers have talked to the Department of Inspections and Appeals about making changes because the services being provided now are very different than they were years ago. Dave Smith added that there is very little in Iowa Code about the services that RCFs provide. Craig Bradke said that RCFs are not just providing custodial care anymore; they are employing highly qualified people to provide treatment services to people who are just out of psychiatric hospitalizations. He also noted that there are economies of scale in an RCF and it does cost more to provide the same service in the community.

Susan Seehase commented that her organization has many people living in some form of RCF. She said that CMS (Centers for Medicare and Medicaid) has said it will be releasing a definition of community and that has the potential to add to the unknowns that we are dealing with and may influence some of the decisions that need to be made. Gano Whetstone asked if the regions will be responsible for the cost of services for people who are not Medicaid eligible. Theresa Armstrong responded that they will be responsible for those who meet the eligibility for non-Medicaid services.

A break for lunch was taken at 12:05 p.m.

The meeting resumed at 1:05 p.m.

DHS/MHDS UPDATE

Rick Shults and Theresa Armstrong presented an update on DHS, MHDS, and related legislative activities.

Transition Funds – House File 160 has been signed by the Governor. It appropriates $11.6 million to 26 counties who applied for transition funding; this is the amount identified under DHS scenario one. The money is to support services for Fiscal Year 2013 and was required to be distributed within two weeks of enactment. That meant

quick work for counties to sign agreements and DHS to get the funds allocated, but it was accomplished.

Patrick Schmitz asked if counties can go back and pay for services they have already provided, and what parameters were placed on spending. Patrick said he hoped that funds which had been depleted might be restored for use at a later time. Theresa responded that ISAC, DHS, the Auditor's Office, and counties met last week and ISAC asked if that could be allowed. It was determined that DHS and the Auditor's Office will provide some guidance and the final decisions will lie with the counties.

Deb Schildroth said the counties were presented with different levels of risk for the use of the funds; the safest use is to pay bills that have been held for non-Medicaid services. There is still a question if dollars can be carried forward or any use other than to pay for services provided in FY 2013.

Senate File 440 – (formerly SF 415) is an appropriations bill and the continuation of redesign. The bill has been amended, has passed the Senate and moved onto the House. The bill started with the recommendations from the redesign workgroups. Provisions include:

- Research based practice – this provision changes references to evidence based practice to research based practice and broadens the definition:

  "Research-based practice" means a service or other support in which the efficacy of the service or other support is recognized as an evidence-based practice, or is deemed to be an emerging and promising practice, or which is part of a demonstration and will supply evidence as to the effectiveness of the service or other support.

- Community Corrections – this provision addresses a difference of opinion about who is responsible for mental health and behavioral services for people under the supervision of community corrections; it says that the responsibility lies with the MHDS system under Medicaid and for non-Medicaid services to the extent other funds are available.

- Eligibility of Populations – last year's legislation allowed for populations currently being served to be grandfathered-in to the new system; this provision amends that to say that a region can serve the whole class of persons (people with developmental disabilities other than ID; people with brain injury; children), not just those being served if some members of that class of persons have previously been served

- Core Services – this provision adds other living arrangements such as RCFs under the domain of community living and added Work Activity Centers and other work activity services under the domain of employment.

- Payments to Counties – this provision clarifies that equalization payments go to the region, not to individual counties within a region.

- Extends Strategic Plan Requirements – under the current Code, county strategic plans are due April 1; this provision extends the due date until after regional plans are in place.

- Risk Pool Payments – the last time Risk Pool funds were allocated was in FY 2012. The current law says that remaining Risk Pool funds would have to be paid back at the end of this year; this provision allows the funds to be carried forward into FYs 2014 and 2015. Only Polk and Clinton counties have carry-forward money.

Dale Todd commented that he thinks there should be a case made for keeping a funding source similar to the risk pool in place as a safety net for regions.

- Maintenance of Services for Counties that Received Transition Funds – these counties would be required to maintain the provision of services as described in their county management plan.

- Equalization Payments – this section was significantly amended; the first Senate bill was for $29.8 mil in equalization payments. The bill now provides for total equalization payments of $42.8 million. The payments would be distributed in two payments: (1) 80% of the total ($31.4 million) that has been identified for growth would go the counties by July 15 and would help address cash flow issues; (2) the remaining $11.4 million has been identified as stabilization funding and would be distributed January 2, 2014.

- Former State Payment Program – this provision directs the former SPP funds ($11.8 million) to go with individuals to their county of residence effective January 2014.

- Detoxification Services – this is the provision that the Commission sent a letter about; the study is still in the bill, but it is now a DHS responsibility, rather than a Commission responsibility.

- County Bills – this provision puts an end date of July 1, 2013 to any adjustments to the amounts owed by counties to the State for the non-federal share of Medicaid services.

- Continued Payments – this provision authorizes continued payments to counties based on their county management plan until those plans are replaced by regional management plans.

- Fiscal Viability Study Committee – this provision authorizes the continuation of the legislative committee and adds four citizen members representing county

supervisors, the community services affiliate of ISAC (Iowa State Association of Counties), service consumers, and service providers.

- Data and Outcomes – the provisions reflecting the recommendations of the Data and Statistical Information and Outcome and Performance Measures workgroups have not been changed.

- Children's Cabinet – these provisions establish a cabinet of high level representation for children services; members would be state agency department heads or designees, including DHS, IDPH, DE, DIA, as well as parents, community based providers, a juvenile court judge or officer, and other community stakeholders.

- Center for Child Health Innovation and Excellence – this provision gives the Department of Public Health the responsibility for looking at the research that is available to inform the system on how to get to good results for children; they would also be charged with staying on top of best practices and grant opportunities, and serve as a policy forum.

INTEGRATED HEALTH HOMES

Theresa Armstrong shared a handout on Integrated Health Homes for Individuals with Serious Mental Illness, noting that it will be a changing document and the section on frequently asked questions will be kept updated. She said the first point of some confusion is the name "health home" – an Integrated Health Home is not a building, not a place - it is a team approach to provide person-centered services. It includes the provision of physical and mental health care as well as employment, community living, and other needed services. Care coordination is provided for all aspects of the person's life and for transitions. The IHHs will be provided through Magellan and serve a much greater number of people than are currently receiving Targeted Case Management. The number of people expected to enroll could be over 24,000 by July 2014. Many of those individuals do not get TCM at this time, so care coordination will be available to many new people.

Rick Shults said that TCM and IHHs are tools made available to states by CMS (Centers for Medicare and Medicaid). TCM has a certain rules and expectations and IHH has a different set of rules and expectations, but there is some overlap. TCM is a single staff person working with an individual to coordinate the person's care. TCMs cannot provide anything that can remotely be considered direct services and must bill for their time in 15 minute increments. Care coordination provided through an IHH is a team of people, including the care coordinator, a nurse, family support or peer support, and others that work together to plan and secure services. The payment is an amount per person per month. There is no absolute wall between care coordination and direct services, and there is an opportunity for more comprehensive care coordination through the team approach. Rick said that there is a group of dedicated people currently doing

a good job using the TCM approach, but care coordination provides a new and different approach that removes some of the barriers Targeted Case Managers face.

Gano Whetstone asked if consumers will be able to choose the professionals on their care team and how many professionals can be on a care team. Rick responded that they will still have a choice of the people who provide them services, and noted that there may be a need to look more closely at how team members can be selected; the number of people on the team would depend on the individual needs of that person.

Jill Davisson said she sees placing this service with Magellan as a conflict of interest. Rick responded that the DHS contract with Magellan has three pieces: services, administrative, and profit. Their profit does not benefit from any savings resulting from services; that money goes into a community reinvestment fund and goes back to fund other services, so in that way it is not an ordinary managed care contract.

Gary Lippe said he has a concern about conflict of interest from a different perspective. He said that if a case manager is employed by the payer of services, it is a potential conflict, so when the provider of the IHH is also the provider of services that would be a potential conflict. Neil Broderick said that all the children with SED initially enrolling with Orchard Place will be current clients so they are expanding their services to those children. He also noted that the IHH provider has certain outcome targets and if they fail to hit those targets, 25% of their daily rate will go away, so they are very motivated for the clients to achieve those outcomes. Gary said that he sees it as a positive that a much broader group of people will be able to access this kind of support and the fact that there is a team provides more expertise and flexibility. Deb Schildroth noted that TCMs work with interdisciplinary teams so there is also a team concept there as well.

Patrick Schmitz said that conflict of interest issues have been and can be handled, such as when provider agencies employ case managers and also provide services. Neil Broderick said that the number of people who can access care coordination under the IHH model will be an 84% increase over those who are eligible for Targeted Case Management, so there will be a need for a lot of care coordinators.

Jill Davisson asked what changes will be coming for county case management. Rick Shults responded that the term TCM is used as if it was a single thing, but it is not. It is TMC provided to specific groups of people. In this case, we are talking about TCM to people with SMI (Serious Mental Illness) moving to the IHH model; TCM to people with intellectual disabilities and other groups will continue as it has been. In pilot projects the TCM is often provided by the agency and that will become the IHH. There will be a six month transition period for people to continue to access TCM as responsibilities are transferred to the IHH; for the first six months that IHH payments begin, TCM services can also continue to run. Gary Lippe said that the variable level of services consumers might receive under the IHH model based on their individual is different from TCM; only individuals with higher levels of need receive TCM services. Rick said caseloads for care coordinators will be higher than for TCM, but will depend on the level of support

needed. Neil Broderick added that Orchard Place has estimated that only about 25% of the people served by the IHHs will have an intensive level of need.

Jill Davisson asked where choice for the individual consumer comes in. Rick responded that the person can choose in or out of the IHH and can also choose to go to another provider. Gary Lippe said that one of the advantages for children is that if they go into a PMIC (Psychiatric Medical Institution for Children) the care coordination continues and is required to help with the transition into and out of facilities.

Health and Human Services Appropriations Bill - Rick Shults said the Senate passed the appropriations bill and it is moving on to the House. The facilities received the amount the Governor recommended. The Senate included $3.3 million for services to children with autism who are not eligible for Medicaid and do not have state employee health insurance. That money can be used to fund ABA (Applied Behavior Analysis) services, which will be a new benefit to a new group of people.

RECOGNITION OF COMMISSION MEMBERS

Jack Willey led the Commission in honoring the five members whose terms are ending this month:

- Lynn Crannell was honored for over eight years of service. Jack thanked her for her loyal participation during a lengthy term of service. Lynn said she appreciates the hard work of everyone on the Commission and has found it a pleasure to be part of the group.

- Richard Heitmann was honored for over seven years of service. Jack thanked him for the concern he has shown for his fellow consumers during his years on the Commission. Richard said he has enjoyed his time on the Commission and wishes everyone luck as they continue their hard work.

- Laurel Phipps was honored for two and a half years of service. Jack thanked him for a great job of representing veterans and their needs and for asking a lot of great questions. Laurel said he has learned a lot in the short time he served on the Commission and appreciates the opportunity.

- Gano Whetstone was honored for six years of service. Jack thanked her for asking questions that made everyone more aware about issues that affect consumers and her special attention to the issues of aging Iowans. Gano said she hopes her service has contributed in some way to improving mental health services in the State of Iowa and that improvement will continue.

- Dale Todd was honored for six years of service, including two years as Chair. Jack said he has appreciated Dale's efforts to make contacts, open doors, and get information to the people who need to hear from the Commission. Dale said he first became a Commission member to help his son, Adam, and other kids

and is grateful for what he has learned, for the relationships he has built, and for the things that have been accomplished.

NEXT MEETING

The next meeting is the annual May retreat and will be the first meeting for the five new Commission members. The Commission will meet jointly with the members of the Iowa Mental Health Planning and Advisory Council on Wednesday afternoon, May 15 and will meet in regular session on Thursday, May 16. This meeting also serves as an orientation session for new Commission members.

Suggestions for agenda items:

- Legislative panel discussion
- Overview of legislative session
- Review of Commission duties and ethics
- Review of administrative rules process
- Further discussion of core services definitions
- Update from Director Palmer
- Discussion about Peer Support/Family Support

The annual election of officers also takes place at the May meeting. Jack Willey appointed Richard Crouch and Neil Broderick to serve as an ad hoc nominating committee. They will present candidates for Chair and Vice-Chair to the Commission for a vote on May 16.

PUBLIC COMMENT

Meghan Klier from Easter Seals commented that there are concerns about vulnerable clients losing their existing relationships with Targeted Case Managers. She said many of the people served by Easter Seals struggle with trust, change, and other issues and are worried they may end up without the services they need.

Deb Eckerman Slack commented that she had heard some talk indicating that IHHs could contract with existing TCM agencies to continue to provide care coordination, but that it appears from today's discussion that that will not be an option. She said she believes we should keep agencies with experience in place.

The meeting was adjourned at 2:45 p.m.

Minutes respectfully submitted by Connie B. Fanselow.